The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-522-4161 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-522-4161 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar year: $2,000/Individual or $4,000/Child(ren) (where eligible for dependent child coverage)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prescription drug coverage, emergency room care, in-network dental and vision care (where eligible) are covered before you meet your calendar year deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Out-of-network Dental: $15/individual or $30 child(ren) (where eligible). There are no other specific calendar year deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$8,550 Individual (Medical - $7,695 & prescription drug coverage - $855)/$17,100 Child(ren) (where eligible) (Medical - $15,390 & prescription drug coverage - $1,710)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing, vision and dental charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.HorizonBlue.com (call 1-800-355-BLUE [2583]) or call 1-800-522-4161 (TTY: 711) for a list of network providers.	This plan uses a provider network and there is no coverage for out-of-network providers in most instances. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as anesthesia and lab work). Check with your provider before

		you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit	Not covered	Deductible applies.
	Specialist visit	$40 copay/ office visit ($20 copay/maternity visit)	Not covered	Deductible applies.
	Preventive care/screening/ immunization	No charge	Covered up to allowance if no provider within 50 miles.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 copay/prescription (retail) & $10 copay/ prescription (mail order)	Not covered	Covers up to a 34-day supply/100 pills (retail); 90-day supply of maintenance medications (mail order or mail at retail).
	Preferred brand drugs	$15 copay/prescription (retail) & $30 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$30 copay/prescription (retail) & $60 copay/ prescription (mail order)	Not covered	
	Specialty drugs	$5/$15/$30 copays (retail)	Not covered	Covers up to a 34-day supply/100 pills. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
If you need immediate	Emergency room care	$500 copay/visit	$500 copay/visit (waived if	You are responsible for out-of-network charges

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention		(waived if admitted)	admitted)	exceeding the Plan's maximum allowed amount. No coverage for non-emergencies.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$50 copay/visit	Not covered	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay + 30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	Deductible applies. Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ office visit (other services + 30% coinsurance)	Not covered	Deductible applies. Contact Beacon Health Options (1-800-843-5503) to ensure that all services are covered.
	Inpatient services	$250 copay + 30% coinsurance	Not covered	Deductible applies. Preauthorization is required for inpatient services.
If you are pregnant	Office visits	$20 copay/initial visit (to confirm pregnancy)	Not covered	Deductible applies. No charge after 1st visit.
	Childbirth/delivery professional services	30% coinsurance	Not covered	Deductible applies.
	Childbirth/delivery facility services	$250 copay + 30% coinsurance	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	$40 copay/visit + 30% coinsurance	Not covered	Deductible applies. Services limited to 60 visits per calendar year. (each visit – 2 hours / maximum of 16 hours per day). Preauthorization is required.
	Rehabilitation services	Inpatient facility: $250 copay + 30% coinsurance Outpatient facility: 30% coinsurance $40 copay/ office visit (also applies for short term therapies)	Not covered	Deductible applies. Limited to 90 days/visits for all therapies combined and for inpatient and outpatient services combined per calendar year. Preauthorization is required
	Habilitation services	30% coinsurance	Not covered	Deductible applies. Preauthorization is

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				required.
	Skilled nursing care	30% coinsurance	Not covered	Deductible applies. Covered only if prior hospitalization and limited to 90 days per calendar year. Preauthorization is required
	Durable medical equipment	30% coinsurance	Not covered	Deductible applies. Preauthorization is required. All rentals or purchases must be through an in-network Horizon Care @ Home provider.
	Hospice services	30% coinsurance	Not covered	Deductible applies. Preauthorization is required. Limit 10 days for respite care.
If your child needs dental or eye care (where eligible)	Children's eye exam	No charge	Approved vision fees	Limited to one exam per calendar year.
	Children's glasses	$10 copay for lenses	Approved vision fees	Limited to one pair of glasses/frames or contact lenses per calendar year.
	Children's dental check-up	No charge	Approved dental fees	Out-of-network deductible applies.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to diagnoses for certain adult post-op dental pain, nausea & vomiting associated chemotherapy or pregnancy)
- Bariatric surgery (if medically necessary)
- Chiropractic care (Limited to 20 visits per calendar year for restorative care only.)
- Dental care (where service period for eligibility is met; $2,500 annual maximum – member only)
- Routine eye care (where service period for eligibility is met)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Plan at 1-800-522-4161 (TTY: 711). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-522-4161 (TTY: 711)].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,770**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.